ILLINOIS HEALTH FACILITIES PLANNING BOARD
INSTRUCTIONS FOR THE COMPLETION OF APPLICATION FOR EXEMPTION
CHANGE OF OWNERSHIP FOR AN EXISTING HEALTH CARE FACILITY

Prior to the submission of an application for exemption for the change of ownership of a health care facility, a letter of intent must be filed. The requirements of a letter of intent are specified at 77 IAC 1130.500(a). No application for exemption will be accepted until the requirements of 77 IAC 1130.500 and 1130.550(b) are met.

The attached form must be used for all transactions proposing a change of ownership of a health care facility. The requirements for issuance of an exemption are contained in 77 IAC 1130.520. Applicants should refer to IAC 1130.140 for definitions of a change of ownership and control of a health care facility. Applicants should also refer to 77 IAC 1130.220(a) for information on who the applicant(s) should be. Note the following requirements and guidelines pertaining to the Application for Exemption:

1. IAC 1130.520(a) prohibits any person from acquiring or entering into an agreement to acquire an existing health care facility prior to receiving approval from the State Board.

2. Complete the application with all applicable attachments. All pages and documents must be on single-sided paper size 8 1/2" x 11". Applicants should note that the required attachments to the application must be labeled and identified by attachment number. FAILURE TO DO SO WILL RESULT IN THE APPLICATION BEING DEEMED INCOMPLETE.

3. It is noted that all applications for exemption for the change of ownership of a health care facility are subject to the opportunity for a public hearing and public hearing requirements (77 IAC 1130.520(c) and (d)).

4. Applicants must submit a complete original application with original signature(s) and required appendices and attachments, as well as the APPLICATION FEE of $2,500 payable by check or money order to the Illinois Department of Public Health. Submit the material to:

   Jeffrey Mark, Executive Secretary
   Illinois Health Facilities Planning Board
   525 West Jefferson Street, Second Floor
   Springfield, Illinois 62761-0001

5. Per IAC 1130.550(b), the State Agency is allowed 30 DAYS (from the date of receipt of the application) to determine the application's completeness. PLEASE REFRAIN FROM TELEPHONING THE STATE AGENCY FOR A STATUS REPORT ON YOUR APPLICATION. STAFF TIME ANSWERING PHONE INQUIRIES TAKES FROM STAFF TIME TO REVIEW APPLICATIONS. The State Agency will contact you if your application is incomplete.

NOTE: **"The Illinois Department of Public Health does not discriminate on the basis of handicap in admission or access to, or treatment or employment in its programs and activities in compliance with Section 504 of the Rehabilitation Act of 1973, as amended. The Equal Employment Opportunity Officer is responsible for coordination of compliance efforts; voice (217) 785-2034; TDD (217) 785-2088."**

Revised September, 2006

(Agency Use Only)		
Fee Received	Y _____	N _____
Exemption #	E-_____	

ILLINOIS HEALTH FACILITIES PLANNING BOARD
APPLICATION FOR EXEMPTION FOR THE
CHANGE OF OWNERSHIP FOR AN EXISTING HEALTH CARE FACILITY

1. INFORMATION FOR EXISTING FACILITY

Current Facility Name_____
Address _____
City _____ Zip Code _____ County _____
Name of current licensed entity for the facility _____
Does the current licensee: own this facility_____ OR lease this facility_____ (if leased, check if sublease □)
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
_____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
_____ Limited Liability Company _____ Other, specify _____
Illinois State Senator for the district where the facility is located: Sen._____
State Senate District Number _____ Mailing address of the State Senator _____
_____
Illinois State Representative for the district where the facility is located: Rep. _____
State Representative District Number _____ Mailing address of the State Representative _____
_____

2. OUTSTANDING PERMITS. Does the facility have any projects for which the State Board issued a permit that will not be completed (refer to 1130.140 "Completion or Project Completion" for a definition of project completion) by the time of the proposed ownership change? Yes □ No □. If yes, refer to Section 1130.520(f), and indicate the projects by Project #
_____

3. FACILITY'S BED OR DIALYSIS STATION CAPACITY BY CATEGORY OF SERVICE (Complete "APPENDIX A" attached to this application)

4. FACILITY'S OTHER CATEGORIES OF SERVICE AS DEFINED IN 77 IAC 1100 (Complete "APPENDIX A" attached to this application)

5. NAME OF APPLICANT (complete this information for each co-applicant and insert after this page).
Exact Legal Name of Applicant _____
Address _____
City, State & Zip Code _____
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
_____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
_____ Limited Liability Company _____ Other, specify _____

6. NAME OF LEGAL ENTITY THAT WILL BE THE LICENSEE/OPERATING ENTITY OF THE FACILITY NAMED IN THE APPLICATION AS A RESULT OF THIS TRANSACTION.
Exact Legal Name of Entity to be Licensed _____
Address_____
City, State & Zip Code _____
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
_____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
_____ Limited Liability Company _____ Other, specify _____

7. BUILDING/SITE OWNERSHIP. NAME OF LEGAL ENTITY THAT WILL OWN THE "BRICKS AND MORTAR" (BUILDING) OF THE FACILITY NAMED IN THIS APPLICATION IF DIFFERENT FROM THE OPERATING/LICENSED ENTITY
Exact Legal Name of Entity That Will Own the Site_____
Address_____
City, State & Zip Code _____
Type of ownership of the current licensed entity (check one of the following:) _____ Sole Proprietorship
_____ Not-for-Profit Corporation _____ For Profit Corporation _____ Partnership _____ Governmental
_____ Limited Liability Company _____ Other, specify _____

8. TRANSACTION TYPE. CHECK THE FOLLOWING THAT APPLY TO THE TRANSACTION:

□ Purchase resulting in the issuance of a license to an entity different from current licensee;
□ Lease resulting in the issuance of a license to an entity different from current licensee;
□ Stock transfer resulting in the issuance of a license to a different entity from current licensee;
□ Stock transfer resulting in no change from current licensee;
□ Assignment or transfer of assets resulting in the issuance of a license to an entity different from the current licensee;
□ Assignment or transfer of assets not resulting in the issuance of a license to an entity different from the current licensee;
□ Change in membership or sponsorship of a not-for-profit corporation that is the licensed entity;
□ Change of 50% or more of the voting members of a not-for-profit corporation's board of directors that controls a health care facility's operations, license, certification or physical plant and assets;
□ Change in the sponsorship or control of the person who is licensed, certified or owns the physical plant and assets of a governmental health care facility;
□ Sale or transfer of the physical plant and related assets of a health care facility not resulting in a change of current licensee;
□ Any other transaction that results in a person obtaining control of a health care facility's operation or physical plant and assets, and explain in "Attachment 3 Narrative Description"

9. APPLICATION FEE. Submit the application fee in the form of a check or money order for $2,500 payable to the Illinois Department of Public Health and append as **ATTACHMENT #1.**

10. **FUNDING.** Indicate the type and source of funds which will be used to acquire the facility (e.g., mortgage through Health Facilities Authority; cash gift from parent company, etc.) and append as **ATTACHMENT #2.**

11. ANTICIPATED ACQUISITION PRICE: $_____

12. FAIR MARKET VALUE OF THE FACILITY: $_____
(to determine fair market value, refer to 77 IAC 1130.140)

13. DATE OF PROPOSED TRANSACTION: _____

14. NARRATIVE DESCRIPTION. Provide a narrative description explaining the transaction, and append it to the application as **ATTACHMENT #3**.

15. BACKGROUND OF APPLICANT (co-applicants must also provide this information). Corporations and Limited Liability Companies must provide a current Certificate of Good Standing from the Illinois Secretary of State. Partnerships must provide the name and address of each partner and specify whether each is a general or limited partner. Append this information to the application as **ATTACHMENT #4**.

16. TRANSACTION DOCUMENTS. Provide a copy of the document(s) which detail the terms and conditions of the proposed transaction (purchase, lease, stock transfer, etc). Applicants should note that the document(s) submitted should reflect the applicant's (and co-applicant's, if applicable) involvement in the transaction. The document must be signed by both parties and contain language stating that the transaction is contingent upon approval of the Illinois Health Facilities Planning Board. Append this document(s) to the application as **ATTACHMENT #5**.

17. **FINANCIAL INFORMATION** (co-applicants must also provide this information). Per 77 IAC 1130.520(b)(3), an applicant must demonstrate it has sufficient funds to finance the acquisition **and** to operate the facility for 36 months by providing evidence of a bond rating of "A" or better (that must be less than two years old) from Fitch, Moody or Standard and Poor's rating agencies or evidence of compliance with the financial viability review criteria (as applicable) to the type of facility being acquired (as specified at 77 IAC 1120). Append as **ATTACHMENT #6**.

18. PRIMARY CONTACT PERSON. Individual representing the applicant to whom all correspondence and inquiries pertaining to this application are to be directed. (Note: other persons representing the applicant not named below will need written authorization from the applicant stating that such persons are also authorized to represent the applicant in relationship to this application).

Name: _____
Address: _____
City, State & Zip Code: _____
Telephone (_____) _____ Ext. _____

19. ADDITIONAL CONTACT PERSON. Consultant, attorney, other individual who is also authorized to discuss this application and act on behalf of the applicant.

Name: _____

Address: _____

City, State & Zip Code: _____

Telephone (_____) _____ Ext. _____

20. CERTIFICATION

I certify that the above information and all attached information are true and correct to the best of my knowledge and belief. I certify that the categories of service, number of beds and/or dialysis stations within the facility will not change as part of this transaction. I certify that no adverse action has been taken against the applicant(s) by the federal government, licensing or certifying bodies, or any other agency of the State of Illinois. I certify that I am fully aware that a change in ownership will void any permits for projects that have not been completed unless such projects will be completed or altered pursuant to the requirements in 77 IAC 1130.520(f) prior to the effective date of the proposed ownership change. I also certify that the applicant has not already acquired the facility named in this application or entered into an agreement to acquire the facility named in the application unless the contract contains a clause that the transaction is contingent upon approval by the State Board.

Signature of Authorized Officer _____

Typed or Printed Name of Authorized Officer _____

Title of Authorized Officer: _____

Address: _____

City, State & Zip Code: _____

Telephone (_____) _____ Date: _____

NOTE: complete a separate signature page for each co-applicant and insert following this page.

APPENDIX A
FACILITY BED AND DIALYSIS STATION CAPACITY AND CATEGORIES OF SERVICE

Complete the following for the facility for which the change of ownership is requested. The facility's bed and dialysis station capacity must be consistent with the State Board's Inventory of Health Care Facilities.

FACILITY NAME _____ CITY: _____

1. Indicate (by placing an "X") the type of facility for which the change of ownership is requested:

   □ Hospital; □ Long-term Care Facility; □ Dialysis Facility; □ Ambulatory Surgical Treatment Center.

2. Provide the bed capacity by category of service:

SERVICE	# of Beds	SERVICE	# of Beds
Medical/Surgical	_____	Nursing Care	_____
Obstetrics	_____	Shelter Care	_____
Pediatrics	_____	DD Adults*	_____
Intensive Care	_____	DD Children**	_____
Acute Mental Illness	_____	Chronic Mental Illness	_____
Rehabilitation	_____	Children's Medical Care	_____
Neonatal Intensive Care	_____	Children's Respite Care	_____

*Includes ICF/DD 16 and fewer bed facilities; **Includes skilled pediatric 22 years and under

3. Chronic Renal Dialysis: Enter the number of ESRD stations: _____

4. Indicate (by placing an "X") those categories of service for which the facility is approved.

_____ Cardiac Catheterization
_____ Subacute Care Hospital Model
_____ Selected Organ Transplantation
_____ Open Heart Surgery
_____ Kidney Transplantation
_____ Postsurgical Recovery Care Center Model

5. Non-Hospital Based Ambulatory Surgery and Ambulatory Surgical Treatment Centers

   Indicate (by placing an "X") if the facility is a □ limited or □ multi-specialty facility and indicate the surgical specialties provided.

_____ Cardiovascular
_____ Dermatology
_____ Gastroenterology
_____ General/Other (includes any procedure that is not included in the other specialties)
_____ Neurological
_____ Obstetrics/Gynecology
_____ Ophthalmology
_____ Oral/Maxillofacial
_____ Orthopedic
_____ Otolaryngology
_____ Plastic Surgery
_____ Podiatry
_____ Thoracic
_____ Urology